TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ahmed Khalifa, MD

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-2239-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Texas Mutual on 1-12-2015 this request was in response to a $183.83 no pay of the $183.83 for the Follow Up performed on 11-26-2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $183.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of **11/26/2014**. The requestor billed code 99214. Texas Mutual reviewed the documentation with the billing. It does not meet 2 of the 3 criteria for billing that code. The exam is problem focused and the medical decision making is straight forward, neither of which rises to the level of 99214.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2014	Evaluation & Management, established patient (99214)	$183.83	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-150 – Payer deems the information submitted does not support this level of service.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 225 – The submitted documentation does not support the level of service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 890 – Denied per AMA CPT Code description for level of service and/or nature of presenting problems.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.

Issues

1. Did the requestor support the level of service for CPT Code 99214 for each date of service as required by 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient.

   The American Medical Association (AMA) CPT code description for 99214 is:

   > Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: **A detailed history; A detailed examination; Medical decision making of moderate complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. [emphasis added]

   The 1995 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Required components for documentation of CPT Code 99214 are as follows:

   - Documentation of the Detailed History:
     - "An *extended* [History of Present Illness (HPI)] consists of at least four elements of the HPI." Review of the submitted documentation finds that the requestor provided a review of five (5) elements of HPI. This meets the documentation requirements for this category.
     - "An *extended* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. [Guidelines require] the patient's positive responses and pertinent negatives for two to nine systems to be documented." Review of the submitted documentation finds that the requestor only reviewed one (1) system, which does not meet the documentation requirements for this category.
     - "A *pertinent* [Past Family, and/or Social History (PFSH)] is a review of the history area(s) directly related to the problem(s) identified in the HPI. [Guidelines require] at least one specific item from any three history areas [(past, family, or social)] must be documented…" Review of the submitted documentation finds that the requestor provided a review of the patient's past history and social history. This meets the documentation requirements for this category.

     The Guidelines state, "To qualify for a given type of history, **all three elements in the table must be met.**" Documentation does not support that the required components of a Detailed History were met.

   - Documentation of a Detailed Examination:
     - A "*detailed examination* – an extended examination of the affected body area(s) and other symptomatic or related organ system(s)." The Guidelines state, "Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or

organ system(s) should be documented. A notation of 'abnormal' without elaboration is insufficient." Review of the submitted documentation supports a limited examination of only the affected body area, which does not meet the documentation requirements for a Detailed Examination.

- Documentation of Decision Making of Moderate Complexity:
  - *Number of diagnoses or treatment options* – The number of problems, whether the problem is diagnosed, and types of diagnostic testing recommended are taken into account. Review of the submitted documentation finds that the requestor reviewed an established, unchanged problem, which supports a minimal level of risk.
  - *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source. Review of the submitted documentation finds that the requestor did not order or review any additional diagnostic tests or discuss the case with an outside source. This meets the requirements for minimal complexity of data.
  - *Risk of complications and/or morbidity or mortality* – "The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines overall risk." Review of the submitted documentation supports that the presenting problem was a stable chronic condition and no diagnostic procedures were ordered or management options discussed. This presents a minimal level of risk.

  "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**." Because none of the elements of this component were met or exceeded, documentation does not support Decision Making of Moderate Complexity.

2. Because none of the components for CPT Code 99214 were met or exceeded, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	May 13, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.